State: Arkansas Filing Company: American Family Life Assurance Company of

Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: EApplications **Project Name/Number:** /A19MS EApps

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: EApplications
State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010

Sub-TOI: MS08I.012 Multi-Plan 2010

Filing Type: Form

Date Submitted: 12/06/2012

SERFF Tr Num: AFLA-128778411

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed Co Tr Num: A19MSEAPPS

Implementation

Date Requested:

Author(s): Rita Golden, Connie Gates
Reviewer(s): Stephanie Fowler (primary)

Disposition Date: 01/03/2013

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

State: Arkansas Filing Company: American Family Life Assurance Company of

Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: EApplications **Project Name/Number:** /A19MS EApps

General Information

Project Name: Status of Filing in Domicile: Authorized
Project Number: A19MS EApps Date Approved in Domicile: 11/13/2012

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Overall Rate Impact: Filing Status Changed: 01/03/2013

State Status Changed: 01/03/2013

Deemer Date: Created By: Connie Gates

Submitted By: Connie Gates Corresponding Filing Tracking Number:

Filing Description:

Filing desription letter is attached under supporting documentation.

Company and Contact

Filing Contact Information

Connie Gates, Policy Analyst cgates@aflac.com
1932 Wynnton Road 706-596-5048 [Phone]
Columbus, GA 31999 706-660-7080 [FAX]

Filing Company Information

American Family Life Assurance CoCode: 60380 State of Domicile: Nebraska Company of Columbus Group Code: 370 Company Type: Life and

1932 Wynnton Road Group Name: Health

Columbus, GA 31999 FEIN Number: 58-0663085 State ID Number:

(706) 323-3431 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? No

Fee Explanation: \$50 x 5 application forms= \$250

Per Company: No

CompanyAmountDate ProcessedTransaction #American Family Life Assurance Company of
Columbus\$250.0012/06/201265510306

State: Arkansas Filing Company: American Family Life Assurance Company of Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: EApplications
Project Name/Number: /A19MS EApps

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/03/2013	01/03/2013

State: Arkansas Filing Company: American Family Life Assurance Company of Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name:EApplicationsProject Name/Number:/A19MS EApps

Disposition

Disposition Date: 01/03/2013

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application for Coverage - Underwritten	Approved-Closed	Yes
Form	Application for Coverage - Guaranteed Issue	Approved-Closed	Yes
Form	Application for Coverage - Underwritten	Approved-Closed	Yes
Form	Application for Coverage - Guaranteed Issue	Approved-Closed	Yes
Form	Application - Medications	Approved-Closed	Yes

State: Arkansas Filing Company: American Family Life Assurance Company of Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name:EApplicationsProject Name/Number:/A19MS EApps

Form Schedule

Lead	ead Form Number: A19MeUWAR							
Item No.	Schedule Item Status	Form Name		Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/03/2013	Application for Coverage - Underwritten	A19MeUWA R	AEF	Initial		67.210	A19MeUWAR.pdf
2	Approved-Closed 01/03/2013	Application for Coverage - Guaranteed Issue	A19MeGIAR	AEF	Initial		68.850	A19MeGIAR.pdf
3	Approved-Closed 01/03/2013	Application for Coverage - Underwritten	A19MeaUW AR	AEF	Initial		67.170	A19MeaUWAR.pdf
4	Approved-Closed 01/03/2013	Application for Coverage - Guaranteed Issue	A19MeaGIA R	AEF	Initial		68.850	A19MeaGIAR.pdf
5	Approved-Closed 01/03/2013	Application - Medications	A19MSMED	AEF	Initial		53.330	A19MSMED.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
ОТН	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

State: Arkansas Filing Company: American Family Life Assurance Company of Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name:EApplicationsProject Name/Number:/A19MS EApps

POLA Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider Schedule Pages

Last	First	MI	
Date of Birth Month/Day/Year	Current Age	Sex: ☐ Male	☐ Female
Social Security Number		-	
Medicare Card No.			
Street AddressStreet or Post Office Box			NI-
City	State	Apt.	
<u> </u>			
Mailing Address (if different from street address) _	Street or Post Office B	OX	Apt. No.
City	State	ZIP	
Telephone () Home □ Work □	l Cell		
Email Address			
Height (feet and inches)	Weight (pounds)		

PL	EASE ANSWER ALL ELIGIBILITY QUE	STIONS			
1.	Are you covered under Medicare Part A? If yes, what is your Part A effective date?	/	/	_	Yes 🗌 No 🗌
2.	If no, what is your eligibility date? Are you covered under Medicare Part B?	/	/	-	Yes 🗌 No 🗌
	If yes, what is your Part B effective date?	/	/	_	
	If no, what is your eligibility date?	/	/	_	
3.	Are you applying during a guaranteed-requested.)	issue perio	d? (If	yes, proof of eligibility m	ay be Yes 🗌 No 🗌
4.	Are you applying during open enrollment?				Yes 🗌 No 🗌
5.	If you are currently on Medicare Disability, stage renal disease (ESRD)?	are you eliç	gible for	Medicare due to disability o	or end-
	IF yes, please select the box that applies.] Disabili	ty ☐ End-Stage Re	enal Disease (ESRD)
	the following Questions 2–8, you are not e				nswer yes to any of
	Have you used tobacco in any form in t	he past 12 r	months?		Yes 🗌 No 🗌
	Are you currently hospitalized, confine home health agency, bedridden, or do mobility aid?		_	•	
	Are you now receiving, or have you ever advised to have treatment or surgery for conditions:				en
	A. Emphysema, chronic obstructive pu chronic pulmonary disorders, or any oxygen?	•	•	• • • • • • • • • • • • • • • • • • • •	
	B. Parkinson's disease, systemic lupus	s, myasthen	ia gravis	s, multiple or lateral sclerosi	_ _
	osteoporosis with fractures, cirrhosi	•		•	Yes No
	C. Alzheimer's disease, senile dementD. Acquired immune deficiency syndro	•	•		Yes ∐ No ∐ Yes ∏ No ∏
	E. Diabetes with peripheral vascular di	` ,		. ,	- -
	disease, retinopathy, or high blood	pressure?			Yes 🗌 No 🗌

	treatment for, been advised to have treatment or su the following conditions:	rgery for, or taken medication for any of	
	 A. Cancer, leukemia, malignant melanoma, Hodgk B. Ulcerative colitis or Crohn's disease? C. Alcoholism or drug abuse? D. Joint replacement? E. Heart attack, heart disease, coronary artery disestroke, transient ischemic attacks (TIA)? F. Congestive heart failure, peripheral vascular disease (not including high blood pressure), head disease (not including high blood pressure), head G. Any amputation caused by disease? H. Degenerative bone disease, or rheumatoid or del. Major depression, bi-polar disorder, schizophremental or nervous disorder requiring psychiatric J. Diabetes treated with insulin or other injectables 	ease, cardiomyopathy, enlarged heart, sease, heart valve disease, carotid artery art rhythm disorders? isabling arthritis? nia, a paranoid disorder, or any other care?	Yes
5.	Have you been advised by a physician that surgery cataracts?	may be required within 12 months for	Yes 🗌 No 🗍
6.	In the last three years, have you been advised by a tests, treatment, or therapy that has not been perfo		Yes 🗌 No 🗌
7.	In the last two years, have you been hospitalized the health care three or more times, or been confined to days?		Yes 🗌 No 🗌
8.	Have you had an organ transplant or been advitransplant?	sed by a physician to have an organ	Yes 🗌 No 🗌
N	IEDICATION HISTORY		
W If	re you taking or have you taken any prescription or drithin the past 12 months? Yes \(\s\) No \(\s\) YES, please list the drug(s) and the condition(s) belepplication addendum will be used.		
	ledication Name (copy from pharmacy label)		
	ate Originally Prescribed		
	losage and Frequency		
L	liagnosis/Condition		
Ν	ledication Name (copy from pharmacy label)		
С	ate Originally Prescribed		
•	osage and Frequency		
	riagnosis/Condition		
Ν	ledication Name (copy from pharmacy label)		
С	ate Originally Prescribed		
D	osage and Frequency		
	iagnosis/Condition		

4. Are you now receiving, or in the last three years have you received medical advice or

Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Bragnosis, Corranion	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
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Diagnosis/Condition	
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Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
-	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

	PR YOUR PROTECTION , the National Association of Insurance Commissioners requires lowing questions about insurance policies or certificates you may have.	s that we ask the
you rigl pla	you lost or are losing other health insurance coverage and received a notice from your prigular are eligible for guaranteed issue of a Medicare supplement insurance policy, or that this to buy such a policy, you may be guaranteed acceptance in one or more of our Medicans. Please include a copy of the notice from your previous insurer with your application. EASE ANSWER ALL QUESTIONS.	you had certain
То	the Best of Your Knowledge:	
1.	(a) Did you turn age 65 in the last six months?	Yes 🗌 No 🗌
	(b) Did you enroll in Medicare Part B in the last six months?	Yes 🗌 No 🗌
	(c) If yes, indicate your effective date.	/ /
2.	Are you covered for medical assistance through the state Medicaid program?	Yes 🗌 No 🗌
	(NOTE TO APPLICANT: If you are participating in a spend-down program and have not met your share of cost, please answer no to the above question.) If yes, answer (a) and (b) below.	
	(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes 🗌 No 🗌
	(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes No No
3.	Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)?	Yes 🗌 No 🗌
	If yes, answer (a)–(g) below. (a) Name of Company	
	Plan Type & Policy/Certificate No.	
	Company Telephone No.	
	Coverage Dates: START DATE	/ /
	(If you are still covered under this plan, leave end date blank.) END DATE	/ /
	(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes 🗌 No 🗌
	If yes, have you received a copy of the replacement notice?	Yes 🗌 No 🗌
	(c) Reason for termination/disenrollment:	
	(d) Planned date of termination/disenrollment:	/ /
	(e) Was this your first time participating in this type of Medicare plan?	Yes 🗌 No 🗌
	(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes 🗌 No 🗌
	(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes 🗌 No 🗌
4.	Do you have another Medicare supplement or Medicare select insurance policy in force?	Yes 🗌 No 🗌
	If yes, answer (a)–(d) below.	
	(a) Name of Company	
	Plan Type & Policy/Certificate No.	
	Company Telephone No.	

	Issue Date		/	/
	(b) Do you intend to replace your current Medicare supplement or Me policy/certificate with this policy?	edicare select	Yes 🗌 I	No 🗌
	(c) Indicate termination date.		/	/
	(d) Have you received a copy of the replacement notice?		Yes 🗌 I	No 🗌
5.	Have you had coverage under any other health insurance within the p (for example, an employer, union, or individual non-Medicare supplement If yes, answer (a)–(c) below.		Yes 🗌 I	No 🗌
	(a) Name of Company			
	Plan Type & Policy/Certificate No.			
	Company Telephone No.			
	Coverage Dates: S	TART DATE	/	/
	(If you are still covered under this plan, leave end date blank.)	ND DATE	/	/
	(b) Reason for termination or disenrollment:	•		
	(c) Planned date of termination/disenrollment:	-	/	/
Do	you or your spouse have other coverage with Aflac?		Yes 🗌	No 🗌
PA	AYMENT METHOD AND INFORMATION			
Υοι	u may be eligible for a policy with a lower premium rate based on your ans	wer to the follo	wing ques	tions:
Ηοι	usehold does not include any type of licensed facility that provides care.			
	es a member of your household with whom you have continuously resided last 12 months have an existing Medicare supplement policy with Aflac? Or	_	No 🗌	
	a member of your household with whom you have continuously resided for 12 months applying for a Medicare supplement policy with Aflac?	the Yes 🗌	No 🗌	
•	ou answered "yes" to either question above, please provide the following in mber:	nformation for t	hat house	hold
	Name (exactly as it appears on Medicare card)			
	Medicare Card No.			
	Aflac Policy Number, if applicable			

Payment Method: Bank Draft		Direct Bill	Credit Card
			(initial monthly premium only)
Mode: (Bar	Monthly ☐ 12 nk Draft NLY)	2 Annual ☐ 06 Semiannual	☐ 03 Quarterly
Monthly Premium \$		Premium Collected \$	

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare supplement insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB) PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc. (formerly known as the Medical Information Bureau), a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at mib.com.

	my application, outline of covant or my closest relative, etc.)			
			()	
Last Name	First Name	MI	Ph	none
Street/P.O. Box		City	State	ZIP Code
I request that a notice of	Protection Against Unintegrated ancellation for nonpayment of		•	n designated below.
Last Name	First Name		MI	l .
Street/P.O. Box				
City	State		ZIP Code	
lapse or termination of the that notice will not be given	the right to designate at least his Medicare supplement insura- ven until 30 days after a premin nm electing NOT to designate an	ince policy for nor um is due and unp	payment of prer paid. I hereby a	mium. I understand
Proposed Insured's Signa	ature:		Date	_

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an outline of coverage for the policy applied for, and (b) a *Guide to Health Insurance for People with Medicare*.

I hereby acknowledge that by typing my name below, I am signing this application electronically and that my electronic signature has the same legal effect as an original, signed document. I certify that the information that I have provided herein is true, correct, and accurate and that if any information is determined to be false is grounds for loss of coverage under this policy.

Signed and Dated at		on	
	City and State	Date	
Proposed Insured's Signature _			
Application completed electronic	cally by		
[Policy Mailing Preference:			
I prefer to receive an electronic	copy of my policy instead of a paper copy.	☐ Yes ☐ No]	

FOR INFORMATION, CALL TOLL-FREE [1.855.207.2078]. VISIT OUR WEB SITE AT AFLAC.COM.

Last	First	MI	
Date of Birth Month/Day/Year	Current Age	Sex: ☐ Male	☐ Female
Social Security Number			
Medicare Card No			
Street AddressStreet or Post Office Box		Apt.	No.
City	State	·	
Mailing Address (if different from street address)	Street or Post Office Box	,	Apt. No.
City			•
Telephone()Home □ Work	⊒ Cell		
Email Address			_
Height (feet and inches)	Weight (pounds)		_

PL	EASE ANSWER ALL ELIGIBILITY QUES	STIONS						
1.	Are you covered under Medicare Part A? If yes, what is your Part A effective date?	/	/					Yes 🗌 No 🗌
2.	If no, what is your eligibility date? Are you covered under Medicare Part B?	/	/					Yes 🗌 No 🗌
	If yes, what is your Part B effective date?	/	/					
	If no, what is your eligibility date?	/	/					
3.	Are you applying during a guaranteed-is requested.)	ssue per	iod? (If yes,	proof c	of eligibility ma	ay be	Yes 🗌 No 🗌
4.	Are you applying during open enrollment?							Yes 🗌 No 🗌
5.	If you are currently on Medicare Disability, stage renal disease (ESRD)?	are you e	ligible f	or Medio	care due	e to disability o	r end-	Yes 🗌 No 🗌
	IF yes, please select the box that applies.	[Disa	bility		End-Stage Re	enal Dis	ease (ESRD)
	OR YOUR PROTECTION, the National A llowing questions about insurance policies o					nissioners req	uires th	nat we ask the
ar su in	you lost or are losing other health insurance eligible for guaranteed issue of a Medica sich a policy, you may be guaranteed accellede a copy of the notice from your previous LEASE ANSWER ALL QUESTIONS.	re supple ptance ir	ement in	surance r more	e policy, of our	or that you ha	ad certa	ain rights to buy
Т	o the Best of Your Knowledge:							
1.	(a) Did you turn age 65 in the last six mon	ths?						Yes 🗌 No 🗌
	(b) Did you enroll in Medicare Part B in the	e last six r	months'	?				Yes 🗌 No 🗌
	(c) If yes, indicate your effective date.							/ /
2.	Are you covered for medical assistance th (NOTE TO APPLICANT: If you are partici your share of cost, please answer no to th If yes, answer (a) and (b) below.	pating in	a spen	d-down			t met	Yes 🗌 No 🗌
	(a) Will Medicaid pay your premiums for the	nis Medica	are sup	plement	policy?			Yes 🗌 No 🗌
	(b) Do you receive any benefits from Medi Part B premium?	icaid OTH	IER TH	AN payr	ment to	vard your Med	icare	Yes 🗌 No 🗌
3.	Have you had coverage from any Medical 63 days (for example, a Medicare Advantal If yes, answer (a)–(g) below. (a) Name of Company	•		•			past	Yes 🗌 No 🗌
	Plan Type & Policy/Certificate No.							
l	Company Telephone No.							

	Coverage Dates:	START DATE	/	/
	(If you are still covered under this plan, leave end date bla	ank.) END DATE	/	1
	(b) If you are still covered under the Medicare plan, do you intend coverage with this new Medicare supplement policy?	d to replace your current	Yes 🗌	No 🗌
	If yes, have you received a copy of the replacement notice?		Yes 🗌	No 🗌
	(c) Reason for termination/disenrollment:			
	(d) Planned date of termination/disenrollment:		1	/
	(e) Was this your first time participating in this type of Medicare plan	<u> ?</u>	Yes 🗌	No 🗌
	(f) Did you drop a Medicare supplement or Medicare select policy/ Medicare plan?	certificate to enroll in this	Yes 🗌	No 🗌
	(g) Is your former Medicare supplement or Medicare sele available?	ct policy/certificate still	Yes 🗌	No 🗌
4.	Do you have another Medicare supplement or Medicare select insur	ance policy in force?	Yes 🗌	No 🗌
	If yes, answer (a)–(d) below.			
	(a) Name of Company			
	Plan Type & Policy/Certificate No.			
	Company Telephone No.			
	Issue Date		/	/
	(b) Do you intend to replace your current Medicare supplem policy/certificate with this policy?	ent or Medicare select	Yes 🗌	No 🗌
	(c) Indicate termination date.		/	1
	(d) Have you received a copy of the replacement notice?		Yes 🗌	No 🗌
5.	Have you had coverage under any other health insurance within example, an employer, union, or individual non-Medicare supplement of yes, answer (a)–(c) below.		Yes 🗌	No 🗌
	(a) Name of Company			
	Plan Type & Policy/Certificate No.			
	Company Telephone No.			
	Coverage Dates:	START DATE	/	/
	(If you are still covered under this plan, leave end date blank.)	END DATE	/	/
	(b) Reason for termination or disenrollment:			
	(c) Planned date of termination/disenrollment:		_/	/
Do	o you or your spouse have other coverage with Aflac?	Yes	□ No □	

You may be eligible for a policy with a lower premium rate based on your answer to the following questions:

You may be eligible for a policy with a lower premium rate based on your answer to the following questions:							
Household does not include any type of licensed facility that provides care.							
Does a member of your household with whom you have continuously resided for the ast 12 months have an existing Medicare supplement policy with Aflac? Or Yes No Or							
•	Is a member of your household with whom you have continuously resided for the last 12 months applying for a Medicare supplement policy with Aflac? Yes No						
If you answered "yes" to either questi member:	If you answered "yes" to either question above, please provide the following information for that household member:						
Name (exactly as it appears of	on Medicare card)						
Medicare Card No.							
Aflac Policy Number, if applic	able						
		_					
Payment Method: Bank Draft	☐ Direct Bill ☐	Credit Card					
		(initial monthly premium only)					
Payment	☐ 12 Annual ☐ 06 Semiannual	☐ 03 Quarterly					
Monthly Premium \$ Premium Collected \$							

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances,

and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

 Counseling services may be available in your state to provide advice concerning your purchase of a Medicare supplement insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB) PRENOTICE

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Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at mib.com.

	my application, outline of on the ormy closest relative, et	•	•	•
Last Name	First Name	MI	<u>()</u> Ph	one
Street/P.O. Box		City	State	ZIP Code

Protectio	n Against Unintende	ed Lapse (Optional)			
I request that a notice of cancellation for	or nonpayment of prem	nium be provided to the pers	son designated below.		
Last Name	First Name		MI		
Street/P.O. Box					
City	State	ZIP Code			
I understand that I have the right to d lapse or termination of this Medicare s that notice will not be given until 30 d typing my name below I am electing No	supplement insurance ays after a premium is	policy for nonpayment of ps due and unpaid. I hereby	remium. I understand y acknowledge that by		
Proposed Insured's Signature:		Date	_		
<u> </u>					
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.					
I wish to apply for a Medicare supplem access to review or print: (a) an outle Insurance for People with Medicare.					
I hereby acknowledge that by typing nelectronic signature has the same legal have provided herein is true, correct grounds for loss of coverage under this	ll effect as an original, s t, and accurate and th	signed document. I certify the	nat the information that		
Signed and Dated atCity a	and State		on Date		
Proposed Insured's Signature					
Application completed electronically by					
[Policy Mailing Preference:					
I prefer to receive an electronic copy of	f my policy instead of a	a paper copy. \square Yes	s □ No]		

FOR INFORMATION, CALL TOLL-FREE [1.855.207.2078]. VISIT OUR WEB SITE AT AFLAC.COM.

A19MeGIAR Page 6 of 6 A19MeGIAR.1

Last	First	MI	
Date of Birth Month/Day/Year	Current Age	Sex: ☐ Male	☐ Female
Social Security Number			
Medicare Card No.			
Street AddressStreet or Post Office Box		Apt.	 No.
City	State	•	
Mailing Address (if different from street addres	ss)Street or Post Office Bo	NY.	Apt. No.
City			
Telephone() Home □ Wo	rk □ Cell		
Email Address			_
Height (feet and inches)	Weight (pounds)		<u>—</u>
PLAN INFORMATION			

PL	EASE ANSWER ALL ELIGIBILITY QUE	STIONS			
1.	Are you covered under Medicare Part A? If yes, what is your Part A effective date?	/	/	_	Yes 🗌 No 🗌
2.	If no, what is your eligibility date? Are you covered under Medicare Part B?	/	/	-	Yes 🗌 No 🗌
	If yes, what is your Part B effective date?	/	/	_	
	If no, what is your eligibility date?	/	/	_	
3.	Are you applying during a guaranteed-requested.)	issue perio	d? (If	yes, proof of eligibility m	ay be Yes 🗌 No 🗌
4.	Are you applying during open enrollment?				Yes 🗌 No 🗌
5.	If you are currently on Medicare Disability, stage renal disease (ESRD)?	are you eliç	gible for	Medicare due to disability o	or end-
	IF yes, please select the box that applies.] Disabili	ty ☐ End-Stage Re	enal Disease (ESRD)
	the following Questions 2–8, you are not e				nswer yes to any of
	Have you used tobacco in any form in t	he past 12 r	months?		Yes 🗌 No 🗌
	Are you currently hospitalized, confine home health agency, bedridden, or do mobility aid?		_	•	
	Are you now receiving, or have you ever advised to have treatment or surgery for conditions:				en
	A. Emphysema, chronic obstructive pu chronic pulmonary disorders, or any oxygen?	•	•	• • • • • • • • • • • • • • • • • • • •	
	B. Parkinson's disease, systemic lupus	s, myasthen	ia gravis	s, multiple or lateral sclerosi	_ _
	osteoporosis with fractures, cirrhosi	•		•	Yes No
	C. Alzheimer's disease, senile dementD. Acquired immune deficiency syndro	•	•		Yes ∐ No ∐ Yes ∏ No ∏
	E. Diabetes with peripheral vascular di	` ,		. ,	- -
	disease, retinopathy, or high blood	pressure?			Yes 🗌 No 🗌

4.	Are you now receiving, or in the last three years have you received medical advice or treatment for, been advised to have treatment or surgery for, or taken medication for any of the following conditions:	
	 A. Cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma? B. Ulcerative colitis or Crohn's disease? C. Alcoholism or drug abuse? D. Joint replacement? E. Heart attack, heart disease, coronary artery disease, cardiomyopathy, enlarged heart, 	Yes No Yes No Yes No Yes No Yes No
	stroke, transient ischemic attacks (TIA)?F. Congestive heart failure, peripheral vascular disease, heart valve disease, carotid artery disease (not including high blood pressure), heart rhythm disorders?	Yes No No
	G. Any amputation caused by disease?	Yes No
	H. Degenerative bone disease, or rheumatoid or disabling arthritis?	Yes No
	I. Major depression, bi-polar disorder, schizophrenia, a paranoid disorder, or any other	
	mental or nervous disorder requiring psychiatric care?	Yes 🗌 No 🗌
	J. Diabetes treated with insulin or other injectables?	Yes 🗌 No 🗌
5.	Have you been advised by a physician that surgery may be required within 12 months for cataracts?	Yes 🗌 No 🗌
6.	In the last three years, have you been advised by a physician to have surgery, medical tests, treatment, or therapy that has not been performed?	Yes 🗌 No 🗌
7.	In the last two years, have you been hospitalized three or more times, received home health care three or more times, or been confined to a nursing facility for more than 30 days?	Yes 🗌 No 🗌
8.	Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes 🗌 No 🗌
N	MEDICATION HISTORY	
V If	Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No No Telescription Yes, please list the drug(s) and the condition(s) below. If more space is needed, an application addendum will be used.	
\vdash	Medication Name (copy from pharmacy label)	
	Date Originally Prescribed	
	Dosage and Frequency	
	Diagnosis/Condition	
$\frac{1}{1}$	Medication Name (copy from pharmacy label)	
	Date Originally Prescribed	
	Dosage and Frequency	
	Diagnosis/Condition	
١	Medication Name (copy from pharmacy label)	
	Date Originally Prescribed	
Ε	Posage and Frequency	
	Diagnosis/Condition	

Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Jagnesis, Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

	PR YOUR PROTECTION , the National Association of Insurance Commissioners requires lowing questions about insurance policies or certificates you may have.	s that we ask the
you rigl pla	you lost or are losing other health insurance coverage and received a notice from your prigular are eligible for guaranteed issue of a Medicare supplement insurance policy, or that this to buy such a policy, you may be guaranteed acceptance in one or more of our Medicans. Please include a copy of the notice from your previous insurer with your application. EASE ANSWER ALL QUESTIONS.	you had certain
То	the Best of Your Knowledge:	
1.	(a) Did you turn age 65 in the last six months?	Yes 🗌 No 🗌
	(b) Did you enroll in Medicare Part B in the last six months?	Yes 🗌 No 🗌
	(c) If yes, indicate your effective date.	/ /
2.	Are you covered for medical assistance through the state Medicaid program?	Yes 🗌 No 🗌
	(NOTE TO APPLICANT: If you are participating in a spend-down program and have not met your share of cost, please answer no to the above question.) If yes, answer (a) and (b) below.	
	(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes 🗌 No 🗌
	(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes 🗌 No 🗌
3.	Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)?	Yes 🗌 No 🗌
	If yes, answer (a)–(g) below. (a) Name of Company	
	Plan Type & Policy/Certificate No.	
	Company Telephone No.	
	Coverage Dates: START DATE	/ /
	(If you are still covered under this plan, leave end date blank.) END DATE	/ /
	(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes 🗌 No 🗌
	If yes, have you received a copy of the replacement notice?	Yes 🗌 No 🗌
	(c) Reason for termination/disenrollment:	
	(d) Planned date of termination/disenrollment:	/ /
	(e) Was this your first time participating in this type of Medicare plan?	Yes 🗌 No 🗌
	(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes 🗌 No 🗌
	(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes 🗌 No 🗌
4.	Do you have another Medicare supplement or Medicare select insurance policy in force?	Yes 🗌 No 🗌
	If yes, answer (a)–(d) below.	
	(a) Name of Company	
	Plan Type & Policy/Certificate No.	
	Company Telephone No.	

Issue Date	/	/
(b) Do you intend to replace your current Medicare supplement or Medicare sele policy/certificate with this policy?	ct Yes 🗌	No 🗌
(c) Indicate termination date.	/	/
(d) Have you received a copy of the replacement notice?	Yes 🗌	No 🗌
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual non-Medicare supplement plan) If yes, answer (a)–(c) below.	_	No 🗌
(a) Name of Company		
Plan Type & Policy/Certificate No.		
Company Telephone No.		
Coverage Dates: START DATE	Ξ /	/
(If you are still covered under this plan, leave end date blank.) END DATE	/	/
(b) Reason for termination or disenrollment:		
(c) Planned date of termination/disenrollment:	/	/
Do you or your spouse have other coverage with Aflac?	Yes 🗌	No 🗌
	Yes 🗌	No 🗌
This section to be completed only by an agent, if applicable.	Yes 🗌	No 🗌
	Yes 🗌	No 🗌
This section to be completed only by an agent, if applicable. Agents will list any other health insurance policies they have sold to the applicant.	Yes 🗌	No 🗌
This section to be completed only by an agent, if applicable. Agents will list any other health insurance policies they have sold to the applicant.	Yes 🗌	No 🗌
This section to be completed only by an agent, if applicable. Agents will list any other health insurance policies they have sold to the applicant. 1. List policies sold that are still in force.	Yes	No 🗌
This section to be completed only by an agent, if applicable. Agents will list any other health insurance policies they have sold to the applicant. 1. List policies sold that are still in force. Name of Company	Yes	No .
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This section to be completed only by an agent, if applicable. Agents will list any other health insurance policies they have sold to the applicant. 1. List policies sold that are still in force. Name of Company Policy/Certificate Number Description of Benefits Effective Date of Coverage Name of Company Policy/Certificate Number Description of Benefits Effective Date of Coverage Name of Company Policy/Certificate Number Description of Benefits Effective Date of Coverage Name of Company	Yes	No

2. List policies so	old in the pas	t five years that	are no longer in force.	
Name of	Company			
Policy/Certific	cate Number			
Description o	f Benefits			
Effective Date	e of Coverag	е		
Name of	Company			
Policy/Certific	cate Number			
Description o	of Benefits			
Effective Date	e of Coverag	е		
Name of	Company			
Policy/Certific	cate Number			
Description o	f Benefits			
Effective Date	e of Coverag	е		
PAYMENT METHO	D AND INF	ORMATION		
You may be eligible for	or a policy wi	th a lower prem	ium rate based on your an	swer to the following questions:
Household does not i	nclude any ty	pe of licensed f	acility that provides care.	
Does a member of yo	our household	d with whom you	u have continuously resided	d for
the last 12 months ha	ave an existin		plement policy with Aflac?	Yes 🗌 No 🗌
l	· · l l-l · · · i	Or		n 41- a
last 12 months applyi			ive continuously resided fo nt policy with Aflac?	r tne Yes □ No □
				information for that household
member:	to citrici qui	conorradove, pr	edde provide the following	miorination for that household
Name (exactl	y as it appea	rs on Medicare	card)	
Medicare Car	d No.			
Afle a Dalian N	l	-1:		
Aflac Policy N	iumber, if ap	olicable		
Payment Method:	Bank Draft		Direct Bill	Credit Card 🗌
				(initial monthly premium only)
	<u> </u>			
	Monthly	☐ 12 Annual	☐ 06 Semiannual	03 Quarterly
ι .	nk Draft NLY)			
Monthly Premium \$		Premium	Collected \$	

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare supplement insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

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	my application, outline of cant or my closest relative, etc			
			()	
Last Name	First Name	MI	Ph	one
Street/P.O. Box		City	State	ZIP Code
	Protection Against Uni	ntended Lapse (Op	tional)	
I request that a notice of o	cancellation for nonpayment o	of premium be provid	ed to the person	designated below.
Last Name	First Nam	e	MI	
Street/P.O. Box				
City	State	Z	IP Code	
lapse or termination of the that notice will not be given	the right to designate at least is Medicare supplement insure ion until 30 days after a prer ion electing NOT to designate	rance policy for non mium is due and unp	payment of premaid. I hereby a	nium. I understand
Proposed Insured's Signa	ature:		Date	
	ngly presents a false or frause information in an application in an application.			
	care supplement insurance pt: (a) an outline of coverage Medicare.			
electronic signature has t	at by typing my name below, he same legal effect as an or true, correct, and accurate age under this policy.	iginal, signed docum	ent. I certify that	the information that
Signed and Dated at			on	1
	City and State			Date
Proposed Insured's Signa	ature			
Signed and Dated at	City and State		on	l
	City and State			Date

Agent's Signature and Writing Number		
[Policy Mailing Preference:		
I prefer to receive an electronic conv of my policy instead of a paper conv	□ Ves □ Nol	

FOR INFORMATION, CALL TOLL-FREE [1.855.207.2078]. VISIT OUR WEB SITE AT AFLAC.COM.

Last	First	MI	
Date of Birth Month/Day/Year	Current Age	Sex: ☐ Male	☐ Female
Social Security Number			
Medicare Card No			
Street AddressStreet or Post Office Box		Apt.	No.
City	State	•	
Mailing Address (if different from street address)	Street or Post Office Box		Apt. No.
City			•
Telephone() Home □ Work □	⊒ Cell		
Email Address			_
Height (feet and inches)	Weight (pounds)		_

PL	EASE ANSWER ALL ELIGIBILITY QUE	STIONS					
1.	Are you covered under Medicare Part A? If yes, what is your Part A effective						Yes 🗌 No 🗌
	date?		/	<u> </u>			
	If no, what is your eligibility date?	/	/				
2.	Are you covered under Medicare Part B?						Yes 🗌 No 🗌
	If yes, what is your Part B effective date?	/	/				
	If no, what is your eligibility date?	/	/				
3.	Are you applying during a guaranteed-is requested.)	ssue peri	od? (li	yes, p	roof of eligibility	may be	Yes 🗌 No 🗌
4.	Are you applying during open enrollment?						Yes 🗌 No 🗌
5.	If you are currently on Medicare Disability, stage renal disease (ESRD)?	are you el	ligible fo	r Medica	re due to disabilit	y or end-	Yes 🗌 No 🗌
	IF yes, please select the box that applies.		Disab	ility	☐ End-Stage	Renal Dis	ease (ESRD)
	DR YOUR PROTECTION , the National Allowing questions about insurance policies of					requires th	nat we ask the
ar su in	you lost or are losing other health insurance eligible for guaranteed issue of a Medica ich a policy, you may be guaranteed accelude a copy of the notice from your previous LEASE ANSWER ALL QUESTIONS.	re suppler eptance in	ment inso	urance p more of	oolicy, or that you our Medicare s	u had certa	ain rights to buy
To	the Best of Your Knowledge:						
1.	(a) Did you turn age 65 in the last six mon	ths?					Yes 🗌 No 🗌
	(b) Did you enroll in Medicare Part B in the	e last six n	nonths?				Yes 🗌 No 🗌
	(c) If yes, indicate your effective date.						/ /
2.	Are you covered for medical assistance th	rough the	state M	edicaid p	rogram?		Yes 🗌 No 🗌
	(NOTE TO APPLICANT: If you are particily your share of cost, please answer no to the lf yes, answer (a) and (b) below.		•	•	ogram and have	not met	
	(a) Will Medicaid pay your premiums for the				•		Yes 🗌 No 🗌
	(b) Do you receive any benefits from Medi Part B premium?				ent toward your M	ledicare	Yes 🗌 No 🗌
3.	Have you had coverage from any Medica 63 days (for example, a Medicare Advanta	•		•		the past	Yes 🗌 No 🗌
	If yes, answer (a)–(g) below.						
	(a) Name of Company						
	Plan Type & Policy/Certificate No.						
	Company Telephone No.						

Coverage Dates:	START DATE	/	/
(If you are still covered under this plan, leave end date blan	k.) END DATE	/	1
(b) If you are still covered under the Medicare plan, do you intend coverage with this new Medicare supplement policy?	to replace your current	Yes 🗌	No 🗌
If yes, have you received a copy of the replacement notice?		Yes 🗌	No 🗌
(c) Reason for termination/disenrollment:			
(d) Planned date of termination/disenrollment:		/	/
(e) Was this your first time participating in this type of Medicare plan?		Yes 🗌	No 🗌
(f) Did you drop a Medicare supplement or Medicare select policy/c Medicare plan?	ertificate to enroll in this	Yes 🗌	No 🗌
(g) Is your former Medicare supplement or Medicare selec available?	t policy/certificate still	Yes 🗌	No 🗌
4. Do you have another Medicare supplement or Medicare select insura	nce policy in force?	Yes 🗌	No 🗌
If yes, answer (a)–(d) below.			
(a) Name of Company			
Plan Type & Policy/Certificate No.			
Company Telephone No.			
Issue Date		/	/
(b) Do you intend to replace your current Medicare suppleme policy/certificate with this policy?	nt or Medicare select	Yes 🗌	No 🗌
(c) Indicate termination date.		/	1
(d) Have you received a copy of the replacement notice?		Yes 🗌	No 🗌
5. Have you had coverage under any other health insurance within example, an employer, union, or individual non-Medicare supplement If yes, answer (a)–(c) below.		Yes 🗌	No 🗌
(a) Name of Company			
Plan Type & Policy/Certificate No.			
Company Telephone No.			
Coverage Dates:	START DATE	/	/
(If you are still covered under this plan, leave end date blank.)	END DATE	1	/
(b) Reason for termination or disenrollment:			
(c) Planned date of termination/disenrollment:		/	
Do you or your spouse have other coverage with Aflac?	Yes	No 🗌	

gei	This section to be completed only by an agent, if applicable. nts will list any other health insurance policies they have sold to the applicant.
1	1. List policies sold that are still in force.
	Name of Company
	Policy/Certificate Number
	Description of Benefits
	Effective Date of Coverage
	Name of Company
	Policy/Certificate Number
	Description of Benefits
	Effective Date of Coverage
	Name of Company
	Policy/Certificate Number
	Description of Benefits
	Effective Date of Coverage
2	2. List policies sold in the past five years that are no longer in force.
	Name of Company
	Policy/Certificate Number
	Description of Benefits
	Effective Date of Coverage
	Name of Company
	Policy/Certificate Number
	Description of Benefits
	Effective Date of Coverage
	Name of Company
	Policy/Certificate Number
	Description of Benefits
	Effective Date of Coverage

PAYMENT METHOD AND INFORMATION

You may be eligible for a policy with a lower premium rate based on your answer to the following questions: Household does not include any type of licensed facility that provides care.						
Does a member of your household with whom you have continuously resided for the last 12 months have an existing Medicare supplement policy with Aflac? Or						
Is a member of your housel 12 months applying for a M	hold with whom you I	nave continuously resided fo policy with Aflac?	r the last Yes			
If you answered "yes" to eit member:	ther question above,	please provide the following	information for that household			
Name (exactly as it	Name (exactly as it appears on Medicare card)					
Medicare Card No.	Medicare Card No.					
Aflac Policy Number, if applicable						
Payment Method: E	Bank Draft	Direct Bill	Credit Card			
			(initial monthly premium only)			
	Monthly ☐ 12 An CDraft LY)	nual 🔲 06 Semiannua	al 03 Quarterly			
Monthly Premium \$	Pre	emium Collected \$				

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or

union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

 Counseling services may be available in your state to provide advice concerning your purchase of a Medicare supplement insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB) PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc. (formerly known as the Medical Information Bureau), a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at <u>mib.com</u>.

	my application, outline of control of my closest relative, etc	• .	•	•
			()	
Last Name	First Name	MI	Ph	one
Street/P.O. Box		City	State	ZIP Code

Protection Against Unintended I	Lapse (Optional)	
I request that a notice of cancellation for nonpayment of premium	n be provided to the person designated be	low.
Last Name First Name	MI	
Street/P.O. Box		
City State	ZIP Code	
I understand that I have the right to designate at least one (1) lapse or termination of this Medicare supplement insurance pol that notice will not be given until 30 days after a premium is dutyping my name below I am electing NOT to designate any personal transfer of the supplementary of the suppleme	licy for nonpayment of premium. I undersue and unpaid. I hereby acknowledge the	stand
Proposed Insured's Signature:	Date	
Any person who knowingly presents a false or fraudulent clarknowingly presents false information in an application for subject to fines and confinement in prison. I wish to apply for a Medicare supplement insurance policy. I ad-	insurance is guilty of a crime and ma	y be given
access to review or print: (a) an outline of coverage for the parameter insurance for People with Medicare.	policy applied for, and (b) a <i>Guide to H</i>	lealth
I hereby acknowledge that by typing my name below, I am sign electronic signature has the same legal effect as an original, sign I have provided herein is true, correct, and accurate and that i grounds for loss of coverage under this policy.	ned document. I certify that the information	that
Signed and Dated at	on	
City and State	Date	
Proposed Insured's Signature		
Signed and Dated atCity and State	on Date	
Agent's Signature and Writing Number		
[Policy Mailing Preference:		
I prefer to receive an electronic copy of my policy instead of a pa	aper copy. ☐ Yes ☐ No]	

FOR INFORMATION, CALL TOLL-FREE [1.855.207.2078]. VISIT OUR WEB SITE AT AFLAC.COM.

A19MeaGIAR Page 7 of 7 A19MeaGIAR.1

Application for Medicare Supplement Insurance (A19MS Series) Application addendum to: American Family Life Assurance Company of Columbus

(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
Administration: [P.O. Box 13547]
[Pensacola, FL 32591]

PROPOSED INSURED INFORMATION		
Proposed Insured's Name (exactly as it a	appears on your application,	
Last	First	MI
MEDICATION HISTORY		
Are you taking or have you taken any prescripast 12 months? Yes No If YES, please list the drug(s) and the conditions.	•	lications within the
Medication Name (copy from pharmacy labe		
Date Originally Prescribed		
Dosage and Frequency		
Diagnosis/Condition		
Medication Name (copy from pharmacy labe) ()	
Date Originally Prescribed		
Dosage and Frequency		
Diagnosis/Condition		
Medication Name (copy from pharmacy labe	el)	
Date Originally Prescribed		
Dosage and Frequency		
Diagnosis/Condition		
Medication Name (copy from pharmacy labe))	
Date Originally Prescribed		
Dosage and Frequency		
Diagnosis/Condition		
Medication Name (copy from pharmacy labe	91)	
Date Originally Prescribed		
Dosage and Frequency		
Diagnosis/Condition		
Medication Name (copy from pharmacy labe	el)	
Date Originally Prescribed		
Dosage and Frequency		
Diagnosis/Condition		

Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Mediaction Name (converge phormacy label)	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Any person who knowingly presents a false or fraudule knowingly presents false information in an application subject to fines and confinement in prison.	
I hereby acknowledge that by typing my name below, I an electronic signature has the same legal effect as an original I have provided herein is true, correct, and accurate and grounds for loss of coverage under this policy.	, signed document. I certify that the information that
Signed and Dated at	on
Signed and Dated at City and State	on Date
Proposed Insured's Signature	

FOR INFORMATION, CALL TOLL-FREE [1.855.207.2078]. VISIT OUR WEB SITE AT AFLAC.COM.

A19MSMED Page 2 of 2 A19MSMED.1

SERFF Tracking #: AFLA-128778411 State Tracking #: Company Tracking #: A19MSEAPPS

State: Arkansas Filing Company: American Family Life Assurance Company of Columbus

TOI/Sub-TOI: MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010

Product Name: EApplications
Project Name/Number: /A19MS EApps

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/03/2013
Comments:	A filing description letter signed by a company officer is attached.	Included in the letter are the re	quired certifications stated above.
Attachment(s):			
A19MSeapps DGltr.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/03/2013
Bypass Reason:	n/a		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/03/2013
Bypass Reason:	These applications will be used when applying for Medicare Supp	olement Policies A19MSARAR,	A19MSCRAR, A19MSDRAR,
	A19MSFRAR, A19MSGRAR, and A19MSNRAR on an electronic	basis through the internet. Thes	se policies and rates were approve
	by your department on August 21, 2012, SERFF Tracking # FRC	S-128603622.	
		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	01/03/2013
Comments:	The outline attached was approved with Medicare Supplement Po	olicies A19MSARAR, A19MSCR	AR, A19MSDRAR, A19MSFRAR,
	A19MSGRAR, and A19MSNRAR and rates by your department of	on August 21, 2012, SERFF Tra	cking # FRCS-128603622.
Attachment(s):			
ACOCRAR.pdf			



Deborah T. Grantham AIRC, HIA, ACSSecond Vice President
Compliance Department

December 6, 2012

Arkansas Insurance Department 1200 West Third Street Little Rock, AR 72201-1904

NAIC # 60380

RE: Electronic Application Forms A19MeUWAR, A19MeaUWAR, A19MeGIAR, and A19MeaGIAR and Underwriting Addendum A19MSMED.

Dear Commissioner:

The above referenced application forms and underwriting addendum are submitted for your review and approval.

These applications will be used when applying for Medicare Supplement Policies A19MSARAR, A19MSCRAR, A19MSDRAR, A19MSFRAR, A19MSGRAR, and A19MSNRAR on an electronic basis through the internet. These policies and A19MS1RAR, application for coverage, were approved by your department on August 21, 2012, SERFF Tracking # FRCS-128603622. The underwriting on Application Forms A19MeUWAR and A19MeaUWAR are the same underwriting questions that were approved on Application Form A19MS1RAR.

Application Form A19MeUWAR and A19MeaUWAR will be used when applying for coverage outside the open enrollment period. The difference between the two applications is that A19MeaUWAR will be completed by an agent and A19MeUWAR will be completed by the applicant only. Although coverage may be applied for online through the internet, it is possible for an applicant to contact our call center for help in completing the form. In that case where an agent will assist, Form A19MeaUWAR will be used. Since A19MeaUWAR is being completed by the agent additional agent information has been added.

Application Form A19MeGIAR and A19MeaGIAR will be used when applying for coverage during the open enrollment period. The difference between the two applications is that A19MeaGIAR will be completed by an agent and A19MeGIAR will be completed by the applicant only. Although coverage may be applied for online through the internet, it is possible for an applicant to contact our call center for help in completing the form. In that case where an agent will assist, Form A19MeaGIAR will be used. Since A19MeaGIAR is being completed by the agent additional agent information has been added.

Underwriting Addendum Form A19MSMED will be used when there is not enough space on the application for the person to enter the medication information.

I certify that the forms submitted herewith comply with the:

- the requirements of Arkansas Insurance Code 23-79-138;
- requirements of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department;
- requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

I certify that this submission meets the *Arkansas Statue Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act. The scores for each form are as follows:*

	FLESCH Score	<u>Grade Level</u>
Application Form A19MeUWAR	67.21	5
Application Form A19MeGIAR	68.85	6
Application Form A19MeaUWAR	67.17	5
Application Form A19MeaGIAR	68.85	5
Application Form A19MSMED	53.33	7

Aflac reserves the right to alter the format of the forms without refiling due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to the wording or content of the application will be filed for prior approval. We intend to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format. The actual presentation of the data on the website may vary slightly only to accommodate a natural presentation flow for an online user experience. However, we will present a rendered image of the completed application once the applicant completes the data. The rendered application image will be identical to the application form submitted in this filing. Further, the application that will print in the policy packet at the time of issue will also be identical to the filed final printed form. We have included brackets in all forms around the address, telephone number, web site, and officer signatures in the event these change in the future.

We have enclosed the required transmittal forms. Should you have any questions or comments concerning this submission, please do not hesitate to call me collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com. A return envelope is enclosed for your convenience.

Sincerely,

Deborah T. Grantham

Deboral Shantta

DTG/CG/cg Enclosures

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

Outline of Medicare Supplement Coverage Benefit Plans A, C, D, F, G and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- Hospitalization Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood First three pints of blood each year.
- Hospice Part A coinsurance

Α	В	С	D	F	F*	G	K	L	М	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, includi 100% Part B coinsu	ing	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100 % Part B coinsurance except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursin Facility Coinsu	g ⁄	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deduc	tible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deduc						
				Part B Excess (100 %	S	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreig Travel Emerg		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
					•		Out- of-pocket limit \$[4660] paid at 100% after limit reached	Out-of -Pocket limit \$[2330] paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$[2070]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

INSERT RATE PAGES

PREMIUM INFORMATION

American Family Life Assurance Company of Columbus may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as underwriting class, state of issue, and your most recent ZIP code of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and American Family Life Assurance Company of Columbus.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: American Family Life Assurance Company of Columbus, Medicare Supplement Administration, [P.O. Box 1553, Pensacola, Florida 32591]. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This Policy may not fully cover all of your medical costs. Neither American Family Life Assurance Company of Columbus nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare* and You for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. American Family Life Assurance Company of Columbus may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your Policy for details.

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1156]	\$0	\$[1156] (Part A
61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve	All but \$[289] a day	\$[289] a day	deductible) \$0
days — Once lifetime reserve days are used:	All but \$[578] a day	\$[578] a day	\$0
—Additional 365 days	\$0	100% of Medicare- eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicareapproved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day	All approved amounts All but \$[144.50] a day	\$0 \$0	\$0 Up to \$[144.50] a day
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co- payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES –			
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as Physician's			
services, inpatient and outpatient			
medical and surgical services and			
supplies, physical and speech			
therapy, diagnostic tests, durable medical equipment,			
First \$[140] of Medicare			\$[140] (Part B
Approved Amounts*	\$0	\$0	deductible)
Remainder of Medicare	ΨΟ	Ψ0	deddelibie)
Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES		,	
(Above Medicare Approved			
Àmounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[140] of Medicare Approved			\$[140] (Part B
Amounts*	\$0	\$0	deductible)
Remainder of Medicare Approved			
Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES - TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED			
SERVICES			
 Medically necessary skilled 			
care services and medical			
supplies	100%	\$0	\$0
Durable medical equipment			Ø[4 40] (D 4 D
First \$[140] of Medicare	фо.		\$[140] (Part B
Approved Amounts*	\$0	\$0	deductible)
Remainder of Medicare	000/	000/	*
Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime	All but \$[1156] All but \$[289] a day	\$[1156] (Part A deductible) \$[289] a day	\$0 \$0
reserve days Once lifetime reserve days are used:	All but \$[578] a day	\$[578] a day	\$0
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicareapproved facility within 30 days after leaving the hospital First 20 days	All approved	\$0	\$0
21 st thru 100 th day	amounts All but \$[144.50] a	Up to \$[144.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES MEDICARE PAYS PLAN PAYS YOU PAY

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY		
MEDICAL EXPENSES -					
IN OR OUT OF THE HOSPITAL					
AND OUTPATIENT HOSPITAL					
TREATMENT, such as					
Physician's services, inpatient					
and outpatient medical and					
surgical services and supplies,					
physical and speech therapy,					
diagnostic tests, durable medical					
equipment,					
First \$[140] of Medicare					
Approved Amounts*	\$0	\$[140] (Part B deductible)	\$0		
Remainder of Medicare					
Approved Amounts	Generally 80%	Generally 20%	\$0		
PART B EXCESS CHARGES					
(Above Medicare Approved					
Amounts)	\$0	\$0	All costs		
BLOOD					
First 3 pints	\$0	All costs	\$0		
Next \$[140] of Medicare					
Approved Amounts*	\$0	\$[140] (Part B deductible)	\$0		
Remainder of Medicare					
Approved Amounts	80%	20%	\$0		
CLINICAL LABORATORY					
SERVICES - TESTS FOR					
DIAGNOSTIC SERVICES	100%	\$0	\$0		
	PARTS A 8	& B			
HOME HEALTH CARE					
MEDICARE APPROVED					
SERVICES					
— Medically necessary skilled					
care services and medical					
supplies	100%	\$0	\$0		
— Durable medical equipment					
First \$[140] of Medicare					
Approved Amounts*	\$0	\$[140] (Part B deductible)	\$0		
Remainder of Medicare					
Approved Amounts	80%	20%	\$0		
OTHER BENEFITS – NOT COVERED BY MEDICARE					
FOREIGN TRAVEL –					
NOT COVEDED BY	I		1		

FOREIGN TRAVEL – NOT COVERED BY			
MEDICARE			
Medically necessary emergency			
care services beginning during			
the first 60 days of each trip			
outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime	20% and amounts

ACOCRAR Page 7 of 19 ACOCRAR.1 Effective: [01-01-2012]

\$50,000.

lifetime maximum.

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends afte have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime	All but \$[1156] All but \$[289] a day	\$[1156] (Part A deductible) \$[289] a day	\$0 \$0
reserve days — Once lifetime reserve days are used:	All but \$[578] a day	\$[578] a day	\$0
Additional 365 days — Beyond the additional	\$0	100% of Medicare-eligible expenses	\$0**
365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[144.50] a day \$0	\$0 Up to \$[144.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co- payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

TICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of care and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided e policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based by difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES –			
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as			
Physician's services, inpatient			
and outpatient medical and			
surgical services and supplies,			
physical and speech therapy,			
diagnostic tests, durable medical			
equipment			
First \$[140] of Medicare	40		6 (4.40) (D. (D.)
Approved Amounts*	\$0	\$0	\$[140] (Part B deductible)
Remainder of Medicare	O = = = =	C	\$ 0
Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES			
(Above Medicare Approved	Φ0	Φ0	A.I.
Amounts)	\$0	\$0	All costs
BLOOD	•		
First 3 pints	\$0	All costs	\$0
Next \$[140] of Medicare			
Approved Amounts*	\$0	\$0	\$[140] (Part B deductible)
Remainder of Medicare Approved	000/	000/	Φ0
Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES - TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$[140] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%	\$0	\$0
	\$0	\$0	\$[140] (Part B deductible)
	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.

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PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and			
board, general nursing and			
miscellaneous services			
and supplies		4	
First 60 days	All but \$[1156]	\$[1156] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[289] a day	\$[289] a day	\$0
91 st day and after:			
 While using 60 lifetime 			
reserve days	All but \$[578] a day	\$[578] a day	\$0
Once lifetime reserve			
days are used:			down
—Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional			
365 days	\$0	\$0	All costs
SKILLED NURSING			
FACILITY CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and entered a Medicare-			
approved facility within 30			
days after leaving the			
hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[144.50] a day	Up to \$[144.50] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$ o	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited co-	Medicare	
requirements, including a	payment/ coinsurance for		\$0
doctor's certification of	outpatient drugs and	co-payment/coinsurance	
terminal illness.	inpatient respite care		

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES –			
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as			
Physician's services, inpatient			
and outpatient medical and			
surgical services and supplies,			
physical and speech therapy,			
diagnostic tests, durable medical			
equipment,			
First \$[140] of Medicare		A 54.463.45	
Approved Amounts*	\$0	\$[140] (Part B deductible)	\$0
Remainder of Medicare	0 11 000/	0 " 000/	Φ0
Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES			
(Above Medicare Approved			
Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[140] of Medicare			
Approved amounts*	\$0	\$[140] (Part B deductible)	\$0
Remainder of Medicare			
Approved amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES – TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled			
care services and medical supplies — Durable medical equipment First \$[140] of Medicare	100%	\$0	\$0
Approved Amounts* Remainder of Medicare	\$0	\$[140] (Part B deductible)	\$0
Approved Amounts	80%	20%	\$0

OTHER SERVICES - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the			
USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime	All but \$[1156] All but \$[289] a day	\$[1156] (Part A deductible) \$[289] a day	\$0 \$0
reserve days — Once lifetime reserve days are used:	All but \$[578] a day	\$[578] a day	\$0
—Additional 365 days — Beyond the additional 365	\$0	100% of Medicare-eligible expenses	\$0**
days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[144.50] a day \$0	\$0 Up to \$[144.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co- payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN G

MEDICARE (PART B) - MEDICAL SERVICES-PER - CALENDAR YEAR

*Once you have been billed \$[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES –			
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as			
Physician's services, inpatient			
and outpatient medical and			
surgical services and supplies,			
physical and speech therapy,			
diagnostic tests, durable medical			
equipment			
First \$[140] of Medicare	# 0	C O	Φ[4.40] (Dowt D. do do otible)
Approved Amounts*	\$0	\$0	\$[140] (Part B deductible)
Remainder of Medicare	Caparally 909/	Conorally 200/	\$0
Approved Amounts PART B EXCESS CHARGES	Generally 80%	Generally 20%	φυ
(Above Medicare Approved	\$0	100%	\$0
Amounts)	φυ	100%	ΨΟ
BLOOD First 2 pints	\$ 0	All agata	\$ 0
First 3 pints	\$0	All costs	\$0
Next \$[140] of Medicare Approved Amounts*	\$0	\$0	¢[140] (Port P doductible)
Remainder of Medicare	ΨΟ	φυ	\$[140] (Part B deductible)
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	00 /0	20 /0	ΨΟ
SERVICES – TESTS FOR	1000/	ф _О	\$ 0
DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN G PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$[140] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[140] (Part B deductible) \$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum

ACOCRAR ACOCRAR.1

PLAN N

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends afte have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

050\"050	MEDICADE DAVO DI ANI DAVO VOLI DAV			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies				
First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime	All but \$[1156] All but \$[289] a day	\$[1156] (Part A deductible) \$[289] a day	\$0 \$0	
reserve days — Once lifetime reserve days are used:	All but \$[578] a day	\$[578] a day	\$0	
— Additional 365 days — Beyond the additional	\$0	100% of Medicare-eligible expenses	\$0**	
365 days	\$0	\$0	All costs	
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[144.50] a day \$0	\$0 Up to \$[144.50] a day \$0	\$0 \$0 All costs	
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0	
HOSPICE CARE				
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co- payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0	

TICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of care and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided e policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based by difference between its billed charges and the amount Medicare would have paid.

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PLAN N

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$[140] of Medicare Approved Amounts*	\$0	\$0	\$[140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved			
Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[140] of Medicare	\$0	All costs	\$0
Approved Amounts* Remainder of Medicare Approved	\$0	\$0	\$[140] (Part B deductible)
Amounts CLINICAL LABORATORY	80%	20%	\$0
SERVICES – TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN N PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$[140] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%	\$0	\$0
	\$0	\$0	\$[140] (Part B deductible)
	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT			
COVERED BY MEDICARE			
Medically necessary emergency			
care services beginning during			
the first 60 days of each trip			
outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime	20% and amounts over
		maximum benefit of	the \$50,000 lifetime
		\$50,000.	maximum.

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